STATE OF MICHIGAN

DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

Before the Director of Insurance and Financial Services

Oximetry Company
Petitioner

v

Blue Cross Blue Shield of Michigan
Respondent

Docket No. 13-001896-DIFS
Case No. 13-920-BC

Issued and entered
this 17th day of April 2014
by Randall S. Gregg
Special Deputy Director

FINAL DECISION

I. BACKGROUND

This case concerns an audit by Blue Cross Blue Shield of Michigan (BCBSM) of one of its participating providers, Oximetry Company. Oximetry conducts sleep studies, diagnostic medical tests used to determine whether an individual has a sleep disorder.

In the audit, BCBSM reviewed claims received from Oximetry and concluded that Oximetry had incorrectly billed home-based sleep studies as more comprehensive and more costly than studies conducted in a laboratory setting. Oximetry denied any improprieties in the way it conducted sleep studies.

When the dispute was not resolved by the parties informally, a Review and Determination proceeding was held by the Director's designee.[1] The proceeding addressed the results of BCBSM's audit and Oximetry's allegation that BCBSM had violated a provision of the Nonprofit Health Care Corporation Reform Act of 1980 (Act 350), BCBSM's governing statute, which requires BCBSM to promptly settle claims where BCBSM's liability had become clear.

In a report issued January 29, 2013, the Director's designee concluded that BCBSM had violated Act 350 and was entitled to recovery of a lesser amount of the disputed payments.

The Review and Determination conclusions were appealed to the Director by Oximetry. A contested case hearing was held on November 18, 2013. The administrative law judge issued a Proposal for Decision (PFD) on February 27, 2014.

Neither party has filed exceptions to the PFD. Michigan courts have long recognized that failure to file exceptions constitutes a waiver of any objections not raised. *Attorney General v. Public Service Comm,* 136 Mich App 52 (1984).

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1. See MCL 550.1404.

II. Findings of Fact

In the PFD, the administrative law judge stated 48 numbered findings of fact. The findings of fact in the PFD are supported by the hearing record. The Director adopts and incorporates the findings of fact as part of this order.

III. Conclusions of Law

In the PFD, the administrative law judge recommended that the Director adopt the following conclusions of law:

- BCBSM did not violate section 402(1)(f) of Act 350, and
- BCBSM provided a reasonable basis for the denial of the sleep study claims at issue in its audit, and
- BCBSM should be permitted to recover a refund of $354,248.37 from Oximetry Company.

The Director finds that the proposed conclusions of law are properly grounded in the facts of this case and are soundly reasoned. The Director adopts and incorporates the conclusions of law as part of this order. The PFD is attached.

IV. Order

It is ordered that:

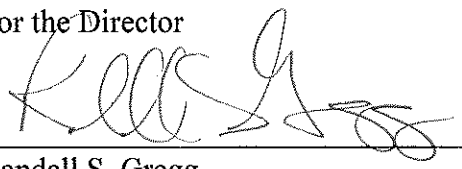
1. The conclusion in the Review and Determination that BCBSM violated section 402(1)(f) of Act 350 is reversed.

2. The conclusion in the Review and Determination that BCBSM was entitled to recover a lesser amount of the disputed payments is reversed.

3. BCBSM may seek a refund from Petitioner of $354,248.37.

Annette E. Flood
Director

For the Director



Randall S. Gregg
Special Deputy Director

STATE OF MICHIGAN
MICHIGAN ADMINISTRATIVE HEARING SYSTEM

IN THE MATTER OF:

Oximetry Company,
Petitioner

v

Blue Cross Blue Shield of Michigan,
Respondent

/

Docket No.: 13-001896-DIFS

Case No.: 13-920-BC

Agency: Department of Insurance and Financial Services

Case Type: DIFS-Insurance

Filing Type: Appeal Subscriber/Provider

Issued and entered
this 27th day of February, 2014
by Lauren G. Van Steel
Administrative Law Judge

PROPOSAL FOR DECISION

PROCEDURAL HISTORY

Appearances: Bryant D. Greene, Attorney at Law, appeared on behalf of Blue Cross Blue Shield of Michigan, Respondent.[1] Oximetry Company, Petitioner, was not represented at hearing.

This proceeding under the Nonprofit Health Care Corporation Act, 1980 PA 350, as amended, MCL 550.1101 *et seq.* (hereafter "Nonprofit Act") commenced in the Michigan Administrative Hearing System with the issuance of a notice of hearing on May 1, 2013, which scheduled a contested case hearing for June 11, 2013. The notice of hearing was issued pursuant to a request for hearing filed on April 30, 2013, by the Department of Insurance and Financial Services along with an Order Referring Complaint for Hearing and Order to Respond, issued by Randall S. Gregg, Special Deputy Director.

The Complaint references allegations set forth in Respondent's Petition for Contested Case Hearing submitted on March 28, 2013, seeking reversal of the Review and Determination issued by the Commissioner's (Director's) Designee on January 29, 2013, that had concluded Respondent was in violation of Section 402(1)(l) of the Nonprofit Act and reduced the amount of its refund request.

[1] Respondent filed the petition in this matter, but the designation of "Petitioner" and "Respondent" as stated on the request for hearing is maintained here to correspond with prior record documents.

On June 6, 2013, the undersigned issued an Order Granting Adjournment and Scheduling Telephone Prehearing Conference. On June 11, 2013, a telephone prehearing conference was held. Mr. Greene appeared on behalf of Respondent. Jayme R. Matchinski, a non-Michigan attorney, appeared on behalf of Petitioner. The Michigan Administrative Hearing System notified Attorney Matchinski of the requirements for Pro Hac Vice temporary admission of non-Michigan attorneys on the record and in writing on June 12, 2013. On June 17, 2013, the undersigned issued an Order Following Prehearing Conference, rescheduling hearing to September 4, 2013. On August 23, 2013, Respondent filed its Witness and Exhibit Lists. Petitioner did not file its witness and exhibit lists.

On August 30, 2013, Attorney Matchinski filed an adjournment request, indicating that she had not yet received Pro Hac Vice temporary admission. On September 13, 2013, the undersigned issued an Order Granting Adjournment, rescheduling the hearing to November 18, 2013.

On November 15, 2013, Respondent filed a Motion for Default Judgment. Petitioner did not file a response to the motion.

On November 18, 2013, the hearing was held as scheduled. Mr. Greene appeared as the attorney on behalf of Respondent. Neither Ms. Matchinski nor any other attorney or representative appeared on behalf of Petitioner. After waiting over 30 minutes from the scheduled time for hearing, the undersigned determined that Petitioner had been properly served with notice of the hearing and had failed to appear. The hearing then proceeded in the absence of Petitioner, pursuant to Section 72(1) of the Administrative Procedures Act, 1969 PA 306, as amended, MCL 24.272(1).

The undersigned then addressed Respondent's Motion for Default Judgment and denied the motion for reasons stated on the record, including that Respondent has the burden of proof in this contested case proceeding and the default language in the Order to Respond is discretionary. The hearing then proceeded with the presentation of Respondent's proofs.

Respondent called Constance Blachut, Manager of Utilization Review for Respondent; Donald Dimcheff, M.D., expert witness in sleep medicine; and R. Bart Sangal, M.D., expert witness in sleep medicine, to testify. In addition, Respondent offered the following exhibits that were admitted into the record as evidence:

1. Respondent's Exhibit No. 1 is the Curriculum Vitae of Donald G. Dimcheff, M.D. and R. Bart Sangal, M.D.

2. Respondent's Exhibit No. 2 is a copy of a CPT Assistant Detail, American Medical Association, September 2002 and November 2011.

3. Respondent's Exhibit No. 3 is a copy of Respondent's policy, Obstructive Sleep Apnea (OSA) Diagnosis and Management, dated June 16, 2009.

4. Respondent's Exhibit No. 4 is a copy of Respondent's Documentation Guidelines for Physicians and Other Professional Providers (effective date July 29, 2008), pp 2 & 6.

5. Respondent's Exhibit No. 5 is a copy of Respondent's Physician and Professional Provider Participation Agreement.

6. Respondent's Exhibit No. 6 is a copy of an August 3, 2011 letter from Dr. Sangal to Dr. Dimcheff concerning audit patient review.

7. Respondent's Exhibit No. 7 is a copy of Respondent's Audit Statistics and Audit Letters: Procedure Code Nomenclature; Primary Decision Code Summary; Decision Code Nomenclature; Corrective Action Report; Sampling Method and Recovery Calculation; January 26, 2011 Audit Letter; April 18, 2011 Reconsideration Letter; and October 14, 2011 Managerial Level Conference Letter.

8. Respondent's Exhibit No. 8 is a copy of Respondent's "Patient Refund Credit Report" for Audit ID 201002496.

9. Respondent's Exhibit No. 9 is a copy of a sample of patients in audit: M.F.; R.H.; and L.W. (initials used for confidentiality).

10. Respondent's Exhibit No. 10 is a copy of Office of Financial and Insurance Regulation Review and Determination File No. 125786.

No evidence was presented on Petitioner's behalf. The record was closed at the conclusion of the hearing.

ISSUES AND APPLICABLE LAW

The central issues presented are:

1) Whether the established facts evidence a violation by Respondent of Section 402(1)(l) of the Nonprofit Act, *supra*, as concluded in the Review and Determination; and

2) Whether Respondent's total request for refund should be reduced from $354,248.37 to $84,578.93, as concluded in the Review and Determination.

Section 402(1)(l) of the Nonprofit Act provides as follows:

> Sec. 402. (1) A health care corporation shall not do any of the following: * * *

> (l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.

Respondent requested a contested case hearing in accordance with Section 404(6) of the Nonprofit Act, *supra,* which states:

> Sec. 404. (6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act. MCL 550.1404(6).

The administrative rules on Procedures for Informal Managerial-Level Conferences and Review by Commissioner of Insurance, 1986 AACS, R 550.101 *et seq.*, state in pertinent part:

> Rule 102. (1) A person who believes that a health care corporation has wrongfully refused his or her claim in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, or has otherwise violated section 402 or sections 403 of Act No. 350 of the Public Acts of 1980, as amended, shall be entitled to a private informal managerial-level conference with the health care corporation.
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> * * *
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> (4) At the time of a refusal to pay a claim, the health care corporation shall provide in writing to the member and, if the claim was made by a provider, to the provider, a clear, concise, and specific explanation of all the reasons for the refusal. This notice shall notify the member or provider of the member's or provider's right to request a private informal managerial-level conference if the member or provider believes the refusal to be in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws. 1986 AACS, R550.102(1)&(4). (Emphasis supplied).
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> Rule 103. (1) Within 10 days of the conclusion of the private informal managerial-level conference, the health care corporation shall provide all of the following information to the grievant:

(a) The proposed resolution of the health care corporation.
(b) The facts, with supporting documentation, upon which the proposed resolution is based.
(c) The specific section or sections of the law, certificate, contract, or other written policy or document upon which the proposed resolution is based.
(d) A statement explaining the person's right to appeal the matter to the commissioner within 120 days after receipt of the health care corporation's written statement provided in subrule (2) of this rule.
(e) A statement describing the status of the claim involved. 1986 AACS, R 550.103(1).

Rule 104. (2) The grievant may appeal to the commissioner within 120 days of the date the person received the health care corporations' proposed resolution . . . 1986 AACS, R 550.104(2).

Rule 105. (3) The commissioner or commissioner's designee shall conduct meetings in a manner which allows the disputing parties to present relevant information to substantiate their positions. 1986 AACS, R 559.105(3). (Emphasis supplied).

Rule 107.(3) The commissioner or the commissioner's designee shall notify the health care corporation and the grievant of the right to request a contested case hearing if a party disagrees with the written decision. 1986 AACS, R 550.107(3). (Emphasis supplied).

Rule 108. (1) If the decision by the commissioner or the commissioner's designee indicates that the grievant's claim was wrongfully refused in violation of section 402 or section 403 of Act No. 350 of the Public Acts of 1980, as amended, being S550.1402 or S550.1403 of the Michigan Compiled Laws, the wrongfully refused claim shall be paid within 30 days of the date the decision is mailed to the health care corporation.

(2) A claim which is payable to a member shall bear simple interest from a date of 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of the claim. 1986 AACS, R 550.108.

FINDINGS OF FACT

Based on the entire record in this matter, including the witness testimony and admitted exhibits, the following findings of fact are established:

1. At times relevant, Oximetry Company, LLC, Petitioner, was a sleep laboratory located in Clinton Township, Michigan and a participating provider of health care services with Blue Cross Blue Shield of Michigan, Respondent. Petitioner was owned and operated by Robert Rudowski, Ph.D. at times relevant, and likely employed or contracted with a physician medical director. [Resp. Exh. 10].

2. At times relevant, Petitioner conducted sleep studies that it considered to be "Type I polysomnography", which is a diagnostic medical test used to determine whether a patient has a sleep disorder that may be related to other medical symptoms and conditions. The patients involved were likely referred to Petitioner by their primary or specialist physicians. [Resp. Exh. 10].

3. Petitioner likely indicated to relevant parties that it provided full 32-channel sleep testing for both the diagnostic study, billed as Current Procedural Terminology (hereafter "CPT") code "95810" and a Constant Positive Airway Pressure (hereafter "CPAP") titration, billed as CPT code "95811". [Resp. Exh. 8 & 9].

4. In this sleep testing, Petitioner's technician or technologist would place sensors on a patient at the patient's home and then leave the premises. There would then be a recording of the sleep tests while the patient was sleeping at his or her home. The next morning, the technician would remove the sensors from the patient at the patient's home. Throughout the testing, an on-call technician would be likely available to go to a patient's home if necessary to correct technical problems. [Resp. Exh. 10].

5. The CPAP testing would be remotely controlled, with data transmitted electronically and wirelessly (audio and visual) in real time to Petitioner's central laboratory in Clinton Township and monitored by a technician. Within 72 hours, a physician would likely interpret the transmitted patient data. [Resp. Exh. 10].

6. Petitioner typically used seven technicians to perform monitoring each night of testing, with one technician usually monitoring two patients. Petitioner billed for these procedures indicating the place of service as "POS3", meaning an office or free-standing laboratory. [Resp. Exh. 8-10].

7. The CPT codes that Petitioner used for this sleep testing, 95810 and 95811, were likely meant in part to reimburse sleep study laboratories in part for costs associated with supporting patient beds in a laboratory. Petitioner did not incur such costs for patient beds in the procedures at issue.

8. Petitioner also provided overnight screening, in which data captured on a device was downloaded at a later time and interpreted by a physician. There was not real-time audio or visual recording transmission for this service, which was CPT "94762". Petitioner billed for this procedure indicating the place of service as an office or free-standing laboratory, even though the data was not transmitted in real time.

9. At times relevant, payment by Respondent for services rendered to member patients was governed by a "Physician and Professional Provider Participation Agreement," which provided that claims for reimbursement filed by Petitioner were subject to audit under certain conditions. [Resp. Exh. 5, p 19].

10. Under the Participation Agreement, a participating physician agreed to report all services to Respondent with "complete and accurate information, including diagnosis with procedure codes approved by BCBSM ..." [Resp. Exh. 5, p 18].

11. The Participation Agreement allowed Respondent to extrapolate its refund requests from samples of patient files that were reviewed in an audit, including procedure code billing errors. [Resp. Exh. 5, p 19].

12. In October 2010, Respondent conducted an audit of claims paid to Petitioner from October 1, 2009 through September 30, 2010, based on a complaint, per Constance Blachut, Manager for Respondent. [Resp. Exh. 7].

13. On January 26, 2011, Respondent issued its audit findings showing an audit sample overpayment in the amount of $103,198.34, with a requested total refund based on projection of $354,248.37. [Resp. Exh. 7].

14. Respondent found in its audit that Petitioner had been billing it for sleep studies performed in patients' home, while the billing code used was for sleep studies performed in a medical office or laboratory. The majority of the denials were deemed to be "WC" or wrong procedure code. When it was otherwise found that there was the wrong type of service, the claim was deemed to be "WP" or wrong placement service. Per Ms. Blachut's credible testimony, both "WC" and "WP" are projectable findings in that they do not involve clinical review. [Resp. Exh. 8 & 9].

15. Ms. Blachut credibly testified that under federal law (HIPAA), all insurers are required to use the most appropriate CPT codes established by the American Medical Association. There is a publication, "CPT Assistant" that responds to questions regarding procedure codes and gives quarterly updates to providers. [Resp. Exh. 2].

16. Per the credible testimony of Ms. Blachut, there was a procedure code at times relevant that Petitioner could have used to bill for sleep studies performed in patients' homes. Petitioner has not disputed that the patients at issue were studied while at home, per Ms. Blachut. She credibly testified that if Petitioner had billed the claims with the proper procedure code, the claims would have been paid.

17. If Petitioner had billed for the sleep studies at issue using procedure codes 95810 and 95811, but indicating that the studies were conducted in the patients' home as place of service "POS4", however, the claims would have been likely rejected by Respondent, per the credible testimony of Ms. Blachut.

18. Donald Dimcheff, M.D. testified as an expert witness in sleep medicine. His Curriculum Vitae is contained in Respondent's Exhibit No. 1. He credibly testified that the standard of care under both Respondent policies and Medicare for procedure codes 95810 and 95811 was for a patient to be in a sleep lab facility, so that a technician would be readily available. The audit found that the place of service was not reported properly by Petitioner. If Petitioner had billed it as place of service "POS4", the claims would not have been paid under Respondent policy or Medicare rules for CPT 95810 and 95811. [Resp. Exh. 3-6].

19. Dr. Dimcheff credibly testified that the proper procedure code for home sleep studies would have been "95806". The CPT code is properly determined by where the patient is at the time of service. Dr. Dimcheff credibly testified that the whole arrangement was wrong for purposes of the standard of care, HIPAA billing rules, the Centers for Medicare and Medicaid Services, and the American Academy of Sleep Medicine.

20. Dr. Dimcheff credibly testified that Respondent's policy for telemedicine requires face-to-face interaction between a doctor and a patient, which was not done here. Dr. Sangal, who regularly practices sleep studies, checked Dr. Dimcheff's conclusions and concurred in them. [Resp. Exh. 3-6].

21. Dr. Dimcheff credibly testified that Respondent was willing to pay Petitioner for sleep tests performed at home, but Petitioner wanted to be paid fully for sleep tests as if they had not been done at home. The

"relative value unit" of a procedure per the federal government takes into account the costs associated with a laboratory.

22. Dr. Dimcheff credibly testified that Petitioner has wanted to be paid the same as a doctor in a laboratory who has many more expenses and upkeep costs with patients sleeping in separate rooms in a laboratory. Petitioner may say that the sleep study tests are the same, but there is no way to prove it. If something goes wrong with the testing when the patient is in his or her home, such as if the monitoring leads fall off the patient's body, it cannot be determined that the test was valid. According to Dr. Dimcheff's credible testimony, when patients were asked in a review about what happened when monitoring leads fell off, they said that no one came to assist them.

23. Per Dr. Dimcheff's credible testimony, one sleep test requires 32 channels and about 1,000 pages of documentation. He credibly testified that it is an "administrative impossibility" for Respondent to review the tests being taken at home on a patient, such that it would have to take Petitioner's word for what testing was actually performed.

24. R. Bart Sangal, M.D. testified as an expert witness in sleep medicine. His Curriculum Vitae is contained in Respondent's Exhibit No. 1. He has been involved with the American Academy of Sleep Medicine in writing CPT codes and with the Centers for Medicare and Medicaid Services in fee setting.

25. Dr. Sangal credibly testified that procedure codes 95810 and 95811 are not reasonably used for sleep studies performed at home. The proper procedure code should be 95806. He reviewed about 10 records in this matter. He found that the Petitioner was not doing standard polysomnography. He found that for every day that there was a study, there was a sheet of paper signed by the patient that the patient was responsible for the equipment that the technician brought to the home and would pick up the next day. [Resp. Exh. 8 & 9].

26. Dr. Sangal credibly testified that the American Medical Association is on record that procedure codes 95810 and 95811 should only be billed for attended studies, with a trained technician or health care professional close enough in proximity to intervene if a patient has arrhythmia, prolonged sleep apnea, the patient has to get up, or other events occur during the testing.

27. Dr. Sangal credibly testified that the financial implications are that when a study is done at home the overhead costs drop off, such as for furniture, physical environment, technologist, electricity and insurance. For the average patient, it is typical for a technologist to intervene four or five

times a night during a sleep study. The Centers for Medicare and Medicaid Services calculated the relative value units for procedure codes 95810 and 95811 at about three times as much as procedure code 95806 meant for home studies, taking into account personnel time and overhead costs.

28. Per Dr. Sangal's credible testimony, the denial of claims following audit was not based on medical necessity, but the wrong procedure code being stated for the location of services.

29. In particular, Dr. Sangal credibly testified that he looked at the worksheet for patient M.F. (initials used for confidentiality) and found that the procedure had been billed for sleep apnea–unspecified and the place of service was "3" or a laboratory. The stated study was polysomnography with four or more parameters in the office. [Resp. Exh. 9].

30. Dr. Sangal found in the test interpretation that there was a "Patient Acceptance of Responsibility" document regarding the patient's responsibility for diagnostic equipment used in the patient's home. He recommended that the claim be denied because it was not conventional polysomnography. He recalled that Petitioner acknowledged in the review process that the procedures were done in the patients' home. [Resp. Exh. 9].

31. Dr. Sangal credibly testified that tor patient R.H., the stated condition was obstructive sleep apnea and was billed as standard polysomnography. Again, it was found that the study was done at home, but billed for 95811 with CPAP titration, which can only be done in an attended study. It would be an inappropriate service to have the patient at home for the CPAP study, per Dr. Sangal's credible testimony. [Resp. Exh. 9].

32. Dr. Sangal credibly testified that for patient L.W., a denial was issued for procedure code 95810 and 95811. Dr. Sangal had the same findings for this patient as for patient R.H. above. [Pet. Exh. 9].

33. Literature concerning CPT codes indicate at times relevant that procedure code "95810" is for attended polysomnography. Under applicable guidelines, "attended" likely means the physical presence of a technologist or health care professional, with sufficient proximity that the health care professional can readily physically respond to emergencies and technical problems throughout the session. [Resp. Exh. 2].

34. On October 12, 2011, the parties had a managerial-level conference. Respondent maintained its requested refund amount of $354,248.37.

35. In January 2013, a review and determination process was conducted through written materials, in which 10 patient records were reviewed. The services for all 10 patients had been denied as the wrong place of service, because in Respondent's view the billing did not reflect the services rendered. Respondent also contended that the questionnaire process used prior to testing did not meet the standard of a history and physical that documented the patients' medical conditions. [Resp. Exh. 10].

36. The Commissioner's Designee found that Petitioner's process did not meet the standard of attended polysomnography, but that not all of Respondent's stated policies for the procedure codes used required that sleep studies be attended. The Commissioner's Designee found that Respondent's August 2009 edition of the Record indicates that procedure code 95806 is a new payable code for most customer groups. [Resp. Exh. 10; Review and Determination, p 18].

37. The Commissioner's Designee further found that since customer data was not available to determine whether procedure code 95806 was payable for all patients in the audit, all such services billed as procedure code 95810 should be approved as procedure code 95806 with the exception of one claim where the patient record was missing. [Resp. Exh. 10; Review and Determination, p 19].

38. The Commissioner's Designee applied a 2010 fee screen of $279.29 for procedure code 95806 and found approved services to total $16,677.70. [Resp. Exh. 10; Review and Determination, p 19].

39. The Commissioner's Designee further agreed with Respondent that there were no procedure codes available for CPAP titration in a home setting and affirmed Respondent's refund request for $43,301.50 under procedure code 95811. [Resp. Exh. 10; Review and Determination, pp 19].

40. The Commissioner's Designee further found that Respondent mistakenly did not have an edit in its system to deny procedure code 94762, which was considered an investigational process under the current policy of Respondent. The Commissioner's Designee therefore found that Respondent was not entitled to pursue a refund for claims under code 94762. [Resp. Exh. 10; Review and Determination, pp 19-20].

41. The record evidence presented at hearing, however, does not show it likely that Respondent was required under the Nonprofit Act to have such an edit in place for code 94762, or that Petitioner was unaware of the investigational nature of the procedure given the publication of Respondent's policy. As such, Respondent is likely entitled to pursue a refund for claims billed by Petitioner under code 94762.

42. The Commissioner's Designee further found that deference should be given to Petitioner with respect to the medical necessity of the procedures because there are no provisions in Respondent's certificates of coverage that address sleep studies. Respondent's proofs at hearing did not specifically address the question of medical necessity (other than the efficacy of CPAP titration in a home study), but rather showed that the denials were primarily based on the use of wrong procedure codes. [Resp. Exh. 10; Review and Determination, p 19].

43. The Commissioner's Designee further did not consider the projected overpayment of $251,050.03 on the basis of the "circumstances" of the audit, that procedure code 96472 is considered investigational but not automatically rejected through edit, and procedure code 95806 for unattended home sleep studies has been a payable procedure since September 1, 2009, even though Respondent stated that the claims would have been rejected as non-covered services. [Resp. Exh. 10; Review and Determination, p 20].

44. Respondent has clarified at hearing through the credible testimony of its witnesses that it does not contend that claims under procedure code 95806 would have been rejected necessarily, but rather that unattended studies should not have been billed as attended studies under procedure codes 95810 and 95811; that sleep studies performed in a patient's home should not have been billed with the stated place of service as an office or laboratory (POS3); and that if the studies under 95810 and 95811 had been billed with place of service as the patient's home (POS4), they would have been rejected.

45. The Commissioner's Designee concluded that Respondent had violated Section 402(1)(l) of the Nonprofit Act by failing to promptly provide a reasonable explanation of the basis for the denial of claims. The re-coded claims totaled $16,677.70 or 28.8% of the total refund requested by Respondent for the claims associated with procedure code 95810. This percentage was applied to Respondent's refund request for procedure code 95810 claims, and recalculated to be $41,301.50. [Resp. Exh. 10; Review and Determination, p 20].

46. The Commissioner's Designee allowed Respondent's refund request for procedure code 95811, being $43,301.50. The total amount allowed was $84,578.92. [Resp. Exh. 10; Review and Determination, p 20].

47. None of the above-listed reasons for disallowing the projected overpayment as stated in the Review and Determination are supported by the record evidence at hearing. Respondent is therefore entitled under

the Participation Agreement to extrapolate a refund recovery from the findings of the audit sample. [Pet. Exh. 5].

48. New legislation, 2012 PA 214, may apply to claims in 2013, but not claims submitted during the audit period, October 1, 2009 through September 30, 2010. It is not likely a factor in this matter. [Resp. Exh. 10].

CONCLUSIONS OF LAW

As the complaining or appealing party, Respondent has the burden of proof to show grounds for reversal or modification of the decision in the Review and Determination. See, *American Way Service Corporation v Commissioner of Insurance*, 113 Mich App 423; 317 NW2d 870 (1982).

Based on the above findings of fact, it is concluded that Respondent has met its burden of proof, to show that its refund request of $354,248.37 should not be reduced. The stated reasons for reduction, as set forth in the Review and Determination, were not supported by a preponderance of evidence presented at hearing. Petitioner failed to appear at hearing to offer any evidence contrary to Respondent's credible proofs.

Further, the Commissioner's Designee concluded in the Review and Determination that Respondent was in violation of Section 402(1)(l) of the Nonprofit Act by failing to promptly provide a reasonable explanation of the basis for denial of the claims associated with procedure code 95810, when Respondent's policy appears to allow for an unattended home study under procedure code 95806, effective September 1, 2009. No other subsection of Section 402(1) was found to have been violated.

Based on the above findings of fact, it is concluded that a preponderance of evidence does not show that Respondent failed to provide a reasonable explanation for the denial of claims. Rather, a preponderance of evidence shows that Respondent properly explained the basis for denial, being that the claims were primarily billed under the wrong procedure codes and could have been billed as home studies, or that they were not properly conducted in a home setting (CPAP titration). Therefore, no violation of section 402(1)(l) of the Act has been established on this record.

PROPOSED DECISION

The undersigned Administrative Law Judge proposes that the Commissioner issue a Final Decision that adopts the above findings of fact and conclusions of law, and reverses the Review and Determination's conclusion that Respondent is in violation of Section 402(1)(l) of the Nonprofit Act.

It is further proposed that the Final Decision reverse the Review and Determination's conclusion that Respondent's refund request should be reduced, and conclude that Respondent is entitled to seek an extrapolated refund from Petitioner in the total amount of $354,248.37.

EXCEPTIONS

Any Exceptions to this Proposal for Decision should be filed in writing with the Department of Insurance and Financial Services, Division of Insurance, Attention: Dawn Kobus, P.O. Box 30220, Lansing, Michigan 48909, within twenty (20) days of issuance of this Proposal for Decision. An opposing party may file a response within ten (10) days after exceptions are filed.

Lauren G. Van Steel
Administrative Law Judge